

## STATE OF HAWAII PREMIUM CONVERSION PLAN ELECTION CHANGE FORM (Form PCP-2)

Premium Conversion Plan (PCP) is a voluntary benefit plan, administered by the State Department of Human Resources Development (DHRD) that allows employees to pay for their health benefit plan premiums on a pretax basis. Premium conversion plans are governed by Section 125 of the Internal Revenue Code (IRC). Submit this form to your Human Resources Office within 90 days of a qualifying event. Changes/cancellations must be consistent with the "change of status" event indicated as defined by Section 125, IRC and shall become effective on a PROSPECTIVE basis from the "Employer's Receipt in Office date"

	Full Name (Last, First,	Middlo)		l act / digits of	Social Socurity	Date of Ou	alifying Evont	
Employee Information		•		Last 4-digits of Social Security Number		Date of Qualifying Event		
Please Check Benefit Plans Affected:	Plans Affected:			□ Vi	sion Plan		Dental Plan	
☐ I elect to CHANGE the a	mount of the PCP	reduction of my pa	y from:					
☐ From 2-party to Family Enrollment				☐ From Family to 2-party or Self-Only Enrollment				
☐ From Self-Only to 2-party or Family Enrollment				☐ From 2-party to Self-Only enrollment				
<ul> <li>Open Enrollment</li> <li>Birth or adoption</li> <li>My Marriage</li> <li>My eligible dependent (re-) joined my household</li> <li>My dependent's loss of eligibility for coverage under a health benefits plan</li> <li>My spouse's health benefits plan is significantly changed or terminated</li> <li>My dependent(s) satisfies the eligibility requirements of the plan (e.g., full-time student, etc.)</li> <li>Other (I have attached a written explanation)</li> </ul>			0 0	<ul> <li>My Divorce/annulment of my marriage</li> <li>Death of my dependent(s)</li> <li>My dependent(s) no longer satisfies the eligibility requirements of the plan (e.g., attainment of age, loss of student status, marriage, etc.)</li> <li>My spouse/dependent child becoming eligible for and electing coverage under other health benefits plan</li> </ul>				
☐ Change of health benefits plan	insurance carrier hecau	ise new residence is out i	of service a	rea of my prese	ent carrier			
☐ Change to new employment cla						not available	ı	
☐ I elect to PARTICIPATE i				ilable of where	my camer 3 plan is	Tiot available	•	
o Self-Only		o 2-Party			o Family Enroll	ment		
<ul> <li>My return from a leave without</li> <li>Birth of a child</li> <li>My loss of health benefits pland</li> <li>Death</li> <li>Divorce/annulment of r</li> <li>Eligibility/employment t</li> </ul>	coverage because of the	e involuntary termination	of my enro	llment or my sp	oouse's enrollment (	due to:		
☐ I elect to TERMINATE		n the Premium Con	version	Plan due to:	<u> </u>			
<ul> <li>Open Enrollment</li> <li>My transfer to a non-eli</li> <li>My loss of eligibility for</li> <li>I will be covered under</li> <li>My marriage. I will be</li> <li>I will be covered as a d</li> <li>My spouse, who is also</li> <li>I will be placed on a lea</li> <li>Other (I have attached)</li> </ul>	igible employment class coverage under a comp my new second employ covered under my spou ependent under my spou a State employee, chase without pay status a written explanation)	sification ponent plan yer's health benefits plan ise's employer's plan puse's new employer's pl inged his/her health plan	or a new h an or retire enrollment	ealth benefits p e health benefit to family cover	olan offered by my s s plan age due to the birth	al/adoption of o	our child	
I understand that I am maki modify my reduction in pay unless (1) th with this current Election Change Form,	e plan is terminated, (2) th	ere is an increase in the am	ount require	d employee contr	ibutions for the covera			
Employee Signature				Date				
, ,,-,-,-,-,-,-,-		Human Resource	s Office (					
Department		Division/School		Ва	argaining Unit			
Employer's Receipt in Office Date			PCP Effec	tive Date				
Human Resources Officer (or employer designee) SIGNATURE			HRO nhon	HRO phone/fax number				